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WHAT MAKES PSYCHOTHERAPY HUMANISTIC?

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Abstract

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WHAT MAKES PSYCHOTHERAPY HUMANISTIC?

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Introduction

Humanistic psychotherapy is presumably one of the major three theoretical orientations to therapy, along with the psychoanalytic and behavioral. I believe that this is widely enough accepted that I do not need to belabor it. It also appears that each of these three psychotherapeutic approaches can be characterized quite clearly--or does it? Although other authors find it easy enough to make generalizations about psychoanalytic and behaviorist therapies, when most authors turn to humanistic therapies, they switch to specific individual therapists instead of generalizing. (e.g., Baron, Byrne and Kantowitz, 1980; Bootzin, 1980; Coleman, Butcher, and Carson, 1980) That is, instead of discussing humanistic therapies in general, they describe Rogers, Frankl, Gendlin, or others. That suggests at least that humanistic therapists are a more diverse group than the others. Whatever the case, it also suggests that there is a need to specify more clearly the things humanistic therapists have in common with one another that help to set them apart from other therapists. I have made some efforts toward that end in other contexts (Tisdale, 1972; Tisdale, in press), and I shall continue them here, adding some opinion research data to my account as well.

Below is a set of ten assertions, which my own experience and reading of the literature have suggested might generally be held by humanistic psychotherapists. I do not believe that each and every one of these assertions will set humanists apart from those of different orientations. Indeed, not all will, as the data will later show. I do believe (or at least did when I began) that most of the ten assertions will be accepted by most humanistic psycho-

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Division of Humanistic Psychology Presidential Address, given at the 91st annual convention of the American Psychological Association, Anaheim, California, August, 1983.

therapists. This will not necessarily be the case for psychoanalysts and behaviorists (separately or jointly), and that on the basis of the acceptance of these assertions we can outline the things which humanistic psychotherapists believe concerning their therapy.

Subjects who were asked about these assertions were selected from the 1981 National Register of Health Service Providers in Psychology. They were chosen to represent the three basic theoretical positions: behaviorist, psychoanalyst, humanist. Four of the possible eleven self-descriptive labels available to listees were of interest here: "behavioral," "psychoanalytic," "Rogerian, client-centered," and "existential-humanistic." To be classified as a behaviorist for our purposes, an individual must have listed "behavioral" as his/her primary orientation, and none of the others as secondary. To be classified humanist, the person must have listed either "Rogerian, client-centered" or "existential-humanistic" as the primary orientation and neither "behavioral" nor "psychoanalytic" as secondary. Within these guidelines, samples were drawn by taking approximately one name for each group on every seventh page of the Register, until 60 of each were obtained. Of the 180 letters sent out, 2 were undeliverable and 111 (62%) were returned. Behaviorists returned 31, humanists 42, and psychoanalysts 38; this difference in the return rates for the three groups was not significant.

Each individual respondent was presented with the ten assertions about therapy and asked to rate that individual's agreement or disagreement with it on a five point Likert type scale. Returns were anonymous (color coded to identify orientation), although individuals were given the opportunity to request a copy of this report on a separate slip of paper. The responses were tabulated for each group and compared using chi square to test for significant differences in the distribution of answers for each item (Table 1). Because of small numbers in many of the five categories, answers were combined into three part tables for statistical purposes: "agree," "neutral," and "disagree."

In addition, to make potential differences somewhat easier to visualize, a number value for each response category was arbitrarily assigned (1 for "strongly disagree," 2 for "mildly disagree," 3 for "neither agree nor disagree," 4 for "mildly agree," and 5 for "strongly agree"). These were then averaged for each group for each item. Although the data actually

do not meet the assumptions needed for this step, it was used here as a heuristic device and was not the basis of any statistical test. The results will be reported as each of the assertions is stated and elaborated (See Figure 1).

Analysis

1. The primary focus of psychotherapy should be on the client's subjective experience, which provides that person with trustworthy self-knowledge. This is phenomenology applied, of course. From this point of view, experience is both primary and largely trustworthy.

The fundamental "given" for each person is that person's own experiencing, and the nature of that is the key to growth and change. The therapeutic process is, then, essentially a process of exploring the client's own experience, whether in a group or individual context. At the point at which formal therapy is terminated, that individual's awareness of self and others should be significantly expanded over what it was at the beginning.

Almost by definition, at the start of therapy significant parts of an individual's total experience are not readibly available to awareness. For any one of a number of reasons, the client or helpee has experienced pain or anxiety in some areas of living. Rather than accept the pain and work through to a new understanding or resolution, the client has in some way refused to experience it. Avoidance continues and may even grow. Only when the individual allows himself or herself to experience the pain in a supportive context is the growth process righted.

It is not, however, simply a matter of catharsis, of freeing bound energy. When one knows fully what the pain is, one also knows what needs to be done to use or eliminate it. Often buried, but nevertheless present, in one's experience is the knowledge of what one needs to do to grow. That knowledge is trustworthy. Resources for healing lie within the individual--resources which have been largely untapped up to that point.

On this assertion, there was indeed a difference in the way in which the different groups responded. Both the psychoanalytic and humanistic therapists agreed with it (mean=4.0), while the behaviorists were clearly uncertain (mean=2.8). This is not particularly surprising, and

TABLE 1

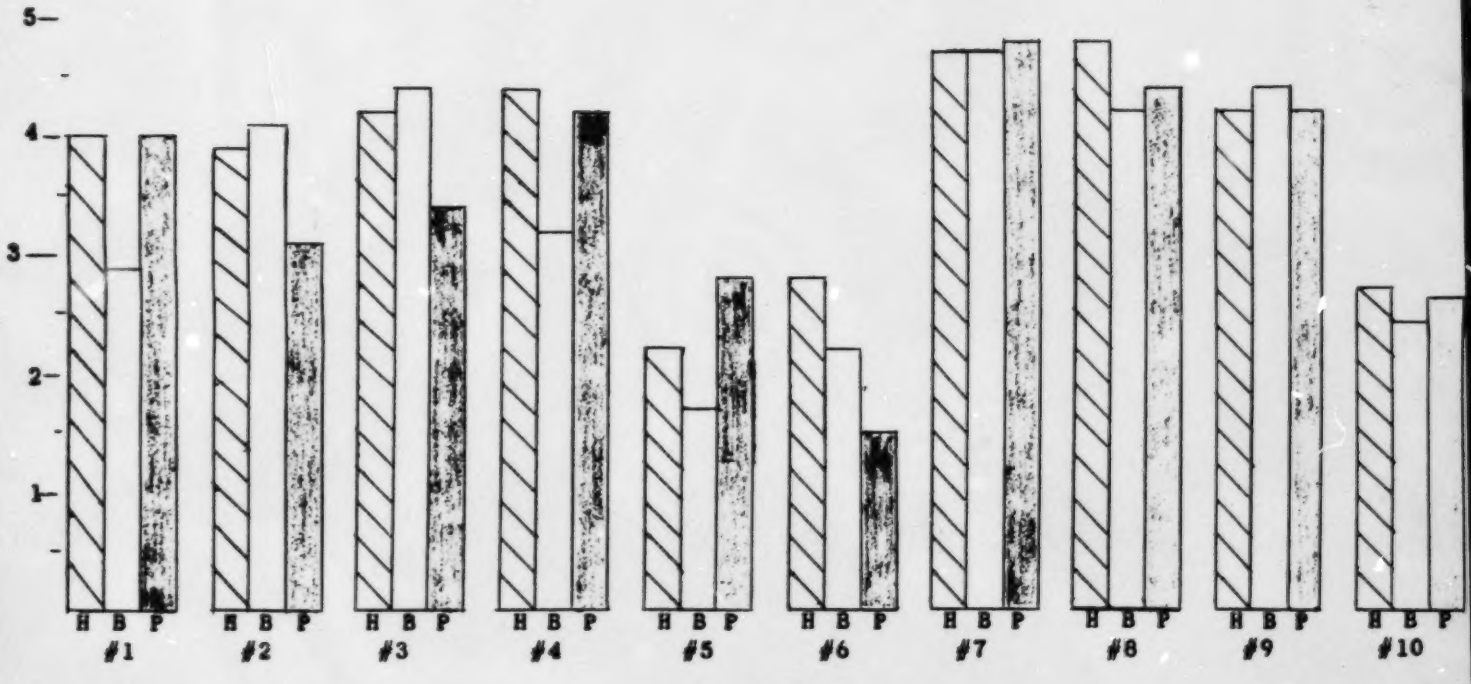
SIGNIFICANT DIFFERENCES IN ASSERTION ENDORSEMENT PATTERNS

Assertion No.	Chi Square
1	27.0***
2	17.8**
3	17.2**
4	22.7***
5	13.7**
6	14.0**
7	2.5
8	6.5
9	5.0
10	4.1

** $p < .01$
*** $p < .001$

FIGURE 1

HUMANISTIC, BEHAVIORISTIC, AND PSYCHOANALYTIC MEAN SCORES ON ASSERTIONS



is as one would expect.

2. Therapy should focus on the present experiences of the client. Just as humanistic therapists generally are not strongly impressed with the determinism of past experience, so they generally do not focus much attention on the individual's past history per se. If a client is troubled, that person is troubled now. If a client is unhappy, this is a current experience, and needs to be addressed as such.

The individual, then, is encouraged to make more direct contact with what is happening in the present. Long discourses on past events or detailed descriptions of future desires are typically discouraged. The client is encouraged to look at her or his present life and present experiences. Indeed, this individual may even be encouraged to look carefully at the therapy situation itself, since this will be the most immediate thing which both client and therapist share. To this end the therapist may try to communicate the therapist's own experiences constructively, as both an encouragement to and a model for the client.

This assertion, however, does not entirely ignore the fact that the person in the therapeutic relationship has a history. It is quite possible, for instance, that the client is carrying around incomplete events and unresolved feelings from the past. If this is the case, then these experiences will be part of the client's present and will be a focus of attention. One does not begin by looking at yesterday, but it is not unusual that in looking at the present one sees both yesterday and tomorrow.

On this item, there again was a significant difference in the way the three groups answered. Humanists (mean=3.9) and behaviorists (mean=4.1) tended to agree that therapy should focus on the present, while the psychoanalytically oriented therapists were more neutral (mean=3.1) on the matter. This seems consistent with traditional emphases, although the differences were not staggering.

3. New and spontaneous ways of thinking and acting on the patient's part are to be actively encouraged. Humanists hopefully are not skeptical of planning, but they are wary of attempts to lock events and experiences into prewritten scenarios. Individuals need to be

stimulated to put aside rigid scripts and to attempt new behaviors and new things in life.

Clients in therapy are often jailed by their own inflexible perceptions and concepts. If they can begin to experiment with less calculated ways of perceiving and acting, they have the opportunity to experience alternate ways of being. Later, as awareness grows and anxities diminish, such individuals will be better able to respond inventively to novel situations as they present themselves naturally in life.

In regard to this assertion, the behaviorists (mean=4.4) and the humanists (mean=4.2) are in agreement, but the psychoanalysts are not so convinced (mean=3.4). The difference is real. Two groups are willing to encourage spontaneity, but those who are psychoanalytic appear less certain that new client behaviors will be any improvement over the old.

4. The therapist's role is more that of a facilitator or catalyst than a diagnostician or giver of advice. Humanistic psychologists do not embrace a model of therapy in which the therapist is regarded as an expert who does something to or for the client. They do not see themselves as analogous to physicians, to whom one comes with a symptom, who renders formal diagnosis, and who then advises the patient what must be done to alleviate the latter's complaint. The paradigm of the therapist as coach or guide is more congenial. Perhaps the most acceptable image of all is that of therapist as catalyst, whose presence allows something to happen which would not otherwise take place.

This does not mean that the therapist has no specialized skills or needs no professional training. As we shall see, the kind of training which is most appropriate may not always be available in graduate school programs, but training is in order. If the therapist is to act as a catalyst, the therapist must know something of the reaction which might take place as client and therapist are brought together. The more the therapist knows, in general, the better. But this does not make the therapist in any way superior to the client, even though it is the client who may change the most.

What is involved here is related to the first assertion (above) and the eighth (below). If the client's own experiencing is trustworthy and the client is to be responsible for her or his own development, then the therapist can only be a participant observer. The therapist's

own knowledge and experiencing are to be put at the service of the client, but this does not make the therapist a guru.

Humanists (mean=4.4) and psychoanalysts (mean=4.2) seem to agree that terms such as "facilitator" or "catalyst" are indeed better descriptions of the therapist's role, while behaviorists do not (mean=3.2). The general tendency of behaviorists to emphasize technical expertise on the part of the therapist is, I believe, responsible for more members of that group disagreeing with the statement than is true for the other groups.

5. Therapy should focus on feelings, not thoughts or beliefs. Humanists traditionally have held that for the purposes of therapy, emotional aspects of the client's perceptual field are more important than other aspects. Blocks to growth involve strong affect, and the client in therapy should pay particular attention to this.

There has been a recent upsurge in cognitive therapies, which emphasize the importance of thought processes in determining perceptions and behavior. I believe that humanistic psychologists, however, while agreeing that respect should be given to thinking, are unconvinced that this plays the key casual role. Therefore, individuals in therapy are encouraged to concentrate on their feelings about things. In therapy groups, for instance, there tend to be few rewards for discussion of intellectual topics. Such discussions are almost always regarded as ways of avoiding important experience, not contacting it. Participants are to shun such "mind-fucking" and communicate what they feel about something, not what they think about it. Beginning therapists or individuals learning basic communication skills are taught to be alert to feelings, and to respond to them, perhaps by using "feeling words" to improve the communication process (e.g., Brammer, 1979; Carkhuff, 1983; Carkhuff and Anthony, 1979; D'Augelli, D'Augelli, and Danish, 1981).

On this item, we again have a difference. Behaviorists (mean=1.7) clearly disagreed with this item more than either the humanists (mean=2.2) or the psychoanalytically oriented (mean=2.8) therapists. In fact, no behaviorists at all expressed any agreement with the statement. What seems surprising is that neither of the other groups strongly endorsed it either. Both tended to be either uncertain or even to disagree somewhat. It is quite possible that the

assertion as it stands requires qualification to be acceptable to humanists.

6. The therapeutic relationship is not qualitatively different from what other relationship should be. Although formal therapy is a somewhat specialized relationship, it is not different in kind from what other relationships should be. What makes effective communication in therapy makes effective communication elsewhere. What produces more awareness in therapy produces more awareness elsewhere. The mutual trust, respect, and responsibility which exist between therapist and client(s) should be the basis of all human relationships. The growth directions taken by clients should be taken by individuals in all sorts of situations.

Expanding awareness, then, is a process which, once well started, does not stop. The therapeutic process does not cease once one has "worked through" all one's difficulties and is "cured." Therapy as such stops when the process is firmly under way, and the client moves from the therapy room to the "real" world. The client continues in this natural living context to do the same things this person was doing in the therapeutic relationship. Therapy becomes living.

None of the three groups was willing to endorse this item, but the psychoanalytic group was clearly more willing to disagree than either of the others. While behaviorists (mean=2.2) and humanists (mean=2.8) expressed uncertainty, psychoanalysts (mean=1.5) supported the idea of a discontinuity between the therapeutic relationship and other relationships. What is surprising is perhaps not so much the fact or trend of differences, but that the humanists expressed so much uncertainty on the matter, even though they were closer to agreeing than either of the other groups.

7. Honesty in communication is critically important for both client and therapist. This proposition is by no means the sole property of humanistic psychologists. It is necessary condition for communication between client and therapist in almost any kind of psychotherapy. It has been said that classical psychoanalysis, for instance, begins with the basic injunction to the patient to be totally honest with the therapist about anything and everything that comes to mind--and then spends the rest of the analysis exploring why the patient doesn't do that.

It is in the group context that the humanistic application of this principle is likely to become most conspicuous. Here all participants (therapist included) are urged to keep their conversations with one another totally honest. Only if this is the case can each individual discover both the feelings which separate this person from others and those which bind this person to others. Since humanists believe that our society typically does not function in terms of honest communication, this experience is generally found to be freeing and trust-building.

It should be noted that the application of this principle does not give either the client or the therapist license to attack others. The honesty (with responsibility) which is meant here is honesty about oneself; one's own feelings, perceptions, and attitudes. It is not an encouragement of evaluations and impressions of other people as if they were objectively correct. It is rich in statements which begin with "I . . . . " It is poor in statements which begin with "You . . . . "

On this item I did not expect any real disagreement among the groups, nor did I find it. All three groups gave it a very strong endorsement, with means of 4.7 for the behaviorist and humanists, and 4.8 for the analysts. On no other item was there as much unanimity. In fact, in the whole sample of responses to this item, only five individuals indicated anything less than either mild or strong agreement.

8. Clients are responsible for their own behavior; human freedom is not illusory. From existentialism comes this assertion: the individual is significantly self-determined and able to change. Complete self-determination need not be argued here. One can insist that, while some limitations are indeed real, they are less important and less straitjacketing than is generally acknowledged. Individuals have freedom enough for choices to be real, and they have responsibility to a commensurate degree.

A clear implication of this is that each individual coming for therapy is largely responsible for the predicament in which that person is living. One is not unhappy "because of" the behavior of one's spouse or one's parents. Difficulty on the job is not "because of" the kinds of people one's associates or superiors are. The client is doing what the client is

doing because the client chooses to do that, not because the client is somehow being forced to do that. Learning to accept such responsibility is one of the tasks of therapy.

In a sense, this assertion may seem harsh. But it carries within it an important truth. If the individual has chosen to be this particular kind of person, then the individual also has the opportunity to choose to be something else. In this lies grounds for optimism, not pessimism. If choice is a reality in the present, it is also a reality for the future.

There is a corollary of this assertion of responsiblity, which has appeared in a different form above. Since the individual is ultimately responsible for her or his own choices and changes the therapist is not responsible for changing the client. If the client comes to therapy, as many do, expecting that the therapist will somehow do something ("intervene") that will make change, the client is doomed to more frustration. What the client hopefully will understand is that the therapist's respect and concern lead the therapist in a different direction: to help create the conditions in which the client can discover the client's own solutions, and make changes only if he or she wishes to do so.

The rank order of scores suggests that humanists might perhaps be convinced of this a bit more strongly than the other groups, but all three therapist groups agree (with means between 4.2 and 4.8) that clients are responsible for their behavior. Humanists do, indeed, endorse this item strongly, but so do the other therapists as well. It is an assertion on which there is near unanimity.

9. The client's body may reflect and prolong some conflicts; explicit attention should be paid to such physical expressions as part of the therapeutic process. While humanistic psychologists are hardly biological determinists, they readily acknowledge that experience has a bodily referrent or aspect.

Therefore, heed is paid to the body as the respository of emotional conflicts, both generally and specifically. Not only are general tension levels important, but so are specific patterns of tension. In this view, emotional trauma or conflicts are reflected in specific areas of dysfunction or tension. These areas may be determined either by their symbolic significance or a predisposing system weakness. If the former, an individual who is afraid of

experiencing tenderness and "soft" feelings might have a set of abdominal muscles chronically contracted and tense. Persons with sexual fears may have their pelvis habitually retracted, with the spinal column showing an exaggerated lumbar curve. It is possible that people will display observable differences in skin tone and coloring in different parts of the body, the capillary blood supply being determined by emotional, not physiological, factors. In all of these kinds of things, physical symptoms are mirroring (and helping to maintain) emotional disorders.

As a result, in therapy a client may be asked to engage in physical "exercises" as a way of making better contact with this person's own experience. Instead of expressing anger verbally, an individual might beat or attack a cushion. Instead of talking about being lonely, a person might physically isolate herself or himself from other group members. From this point of view, both individual and group therapy proceed more effectively by taking account of muscular and bodily dimensions of a client's difficulties.

On this, as on the matter of responsibility above, there was agreement by all three groups. With means all above 4.0, the therapists in our sample endorsed this assertion, although we do not know how far they would be willing to carry it.

10. The therapist's level of adjustment presents an upper limit to the client's adjustment; a client cannot grow beyond the therapist's level of growth. What is meant here is deceptively simple, but with some far-reaching implications. It means that the upper limit of growth, of awareness expansion, of accurate experiencing, for any client is the level reached by the therapist with whom the client is interacting. To use Carkhuff's model (Carkhuff, 1969; Carkhuff and Berenson, 1977) with a scale of one to five to designate different levels of functioning, a client has the possiblity of reaching five only if the therapist has. If the therapist operates on a three, or average level, the client will surely be limited to that level as well.

There is a corollary to this. If the therapist is functioning at a lower level than the client, the client is likely to deteriorate in the relationship rather than grow! A therapist operating at a two level with a client at three will eventually inhibit rather than enhance

that client's growth. If both are at three, no significant change will take place.

If accepted, this has important consequences for professional training. In general, humanists do find "typical" graduate school programs far too oriented toward cognitive information. If the functioning level of the therapist presents a ceiling for client growth, then training should be designed to enhance the functioning of the therapist. This is also why humanistic psychotherapists are often less impressed by formal credentials than many other therapists, and often unexcited about the value for clients of most present licensing and certification requirements.

Although an inspection of the distribution of responses to this assertion suggested that humanists and psychoanalysts polarized on it somewhat more than behaviorists, there was not in fact any significant difference among the three groups. All showed a distinct tendency toward disagreeing with the idea that therapist adjustment presents an automatic upper limit to client adjustment. The means were 2.7 for humanists, 2.6 for analysts, and 2.4 for behaviorists. The lack of acceptance of this assertion by the humanistic group was an unexpected finding of the survey.

Conclusion

In setting forth a set of beliefs held to be typical of a group of individuals, one takes a calculated risk in asking members of that group whether or not they agree. The ideal supportive distribution of responses would have been one in which the humanistic group endorsed all ten assertions, while at least one of the other two did not. Such a pattern was not reached for all ten items.

In six instances there were significant differences in the response patterns, and these patterns clearly could be used to separate the groups. Of these six, however, two ("focus on feelings" and "therapeutic relationship quality") were not really endorsed by any of the three groups. The other four ("subjective experience," "present experience," "new ways of acting," and "therapist's role") did show differentiating patterns of agreement.

For the other four items, there were no significant differences among the three groups. One of these ("communication honesty") was not expected to be different at this level, and it

was not. In two instances ("individual responsibility" and "body expression"), the humanists did indeed endorse the items strongly, but, unexpectedly, so did the other two groups. For the remaining assertion ("therapist adjustment level,"), the humanists joined the others in expressing lack of support for it.

What are the possible explanations for these results? Perhaps the simplist is that clearly not all of these ten assertions are differentially supported by humanistic psychotherapists, and the list should be trimmed or modified to include only those which are. Another possibility is that the indicators for separating the three criterion groups were somehow imprecise, and that we do not have three clearly separate groups responding. Another possibility is that the brevity of the way in which the assertions were stated, with no explanation or elaboration, did not allow any of the groups to understand fully their import--and if those responding had understood more clearly, the results would have more closely approximated the predictions. The final possibility is that humanistically oriented therapists who meet the formal requirements for and take the trouble to get themselves listed in the National Register are not representative of all humanistically oriented therapists. In the light of a tendency of at least some humanists to eschew formal credentialling, the latter possibility should not be too lightly dismissed.

What, then, does make psychotherapy humanistic? In terms of intellectual assertions (which may miss some of the most important nuances), humanists agree (different from others) that therapy should focus on the conscious, present, experience of the client, that client spontaneity in thinking and acting is desirable, and that the therapist's role is best described as that of a facilitator. How much relative attention should be paid to feelings and the degree to which the therapeutic realtionship provides a model for other relationships need to be explored more carefully, although the humanists are different on both of these (less rejecting than the behaviorists on both, but more rejecting than the psychoanalysts on one and less on the other, respectively). All the therapists here agree that honesty is essential for client and therapist, that the client is self-responsible, that in some way bodily expressions

of conflict are important, and that therapist adjustment level is not necessarily a limit to client growth.

With such a summary, I believe we have the beginnings of an answer to the question, although certainly not a final answer. I invite others to build on this, to refine and extend it, so that the things which unite all humanistic therapists might be clearly and plainly articulated.

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